Iowa Department of Human Services

Iowa Wellness Plan
Patient Manager Guide

February 2014

PROGRAM OVERVIEW

The Iowa Wellness Plan is for individuals who are ages 19 through 64 who do not have access to Medicare or other comprehensive Medicaid coverage, and who are not eligible for cost-effective Employer Sponsored Insurance (ESI) coverage. Individuals, who do not have access to cost-effective ESI coverage, with income up to and including 100 percent of the FPL based on Modified-Adjusted Gross Income (MAGI) methodology, are considered eligible, and individuals with income up to 133 percent of the FPL who are medically frail will be considered eligible.

The goals of the Iowa Wellness Plan are to:

- Enhance quality and continuity of care
- Ensure appropriate utilization of health care services
- Encouraging Member engagement in their own health care
- Access and engagement of primary health care for low-income Iowans

Patient management has been shown to enhance the continuity of care that comes from a strengthened provider-patient relationship. Research has also shown that a strong provider-patient relationship will encourage early diagnosis and intervention, promote good health outcomes, and support efforts to meet these goals.

In the Iowa Wellness Plan, members select or are assigned to one primary care provider (doctor of medicine or osteopathy, nurse practitioner), a Federally Qualified Health Care Center (FQHC), or a Rural Health Center (RHC), referred to as a Patient Manager. The Patient Manager provides the member a 'medical home.' This provider has the responsibility of coordinating and monitoring necessary medical care. The Patient Manager acts as a monitor to assure appropriate utilization of services and also serves as an advocate for the member who might not otherwise seek appropriate medical care.

Also, the Patient Manager is responsible for authorizing all referrals with the exception of those services that do not require a referral. The list of services that members can receive without a referral includes:

- Emergent Services
- Skilled Care (limited to 120 days annually)
- Prescription Drugs
- Chiropractic Services
- Ambulance Services
- Family Planning Services
- Vision Care Exams
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Rehabilitative Services (limited to a combined 60 visits annually)

PROVIDER PARTICIPATION

Physicians, nurse practitioners, or any actively enrolled practitioner who practices primary care medicine may participate as an Iowa Wellness Plan Patient Manager. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may also serve as Iowa Wellness Plan providers. When an RHC or FQHC is the provider, the clinic as a whole and not an individual practitioner within the organization is with whom the member is enrolled.

The following specialties may participate as Iowa Wellness Plan patient managers:

- General Practice
- Family Practice
- Internal Medicine
- OB/GYN

PATIENT MANAGER RESPONSIBILITIES

The patient manager's overall role is to provide the members a 'medical home.' The patient manager provides primary care and appropriate referrals for medical services from other providers. He or she assists the member in becoming a responsible user of medical services. He/she is responsible for either providing services, or referring another provider to do so, for all members enrolled with them as their patient manager.

As the sole point of access into the health care system for Iowa Wellness Plan members the patient manager must provide for or arrange for 24-hour per day, seven days per week provider coverage. The patient manager or designee must be available to the member because the member has no alternative but to go to the patient manager for non-emergent care. The patient manager should inform the member of normal office hours and explain the procedures to follow when the office is closed. A single 24-hour access telephone number must be provided by the Patient Manager to the IME. Consideration has been made to minimize the administrative burden for providers, but the Patient Manager is expected to keep complete and accurate patient records. While paper referrals are not required by DHS, all referrals must be documented by both the Patient Manager and treating provider. This documentation is no more detailed than the guidelines established by the Department of Health for complete patient records.

When the Patient Manager's office is closed, treating providers must be able to call the 24-hour number to receive instructions on providing non-emergent medical care. The Patient Manager (or qualified medical professional who is authorized to make decisions on behalf of the Patient Manager) must be available within 30 minutes to answer questions, give advice for non-emergent situations, or to refer for treatment.

Patient Managers will coordinate member care by conducting referrals, managing and monitoring member health, and assisting with management of complex and chronic conditions. PMs will be paid on a fee-for-service basis and provided a per member per month (PMPM) payment to coordinate member care and provide referrals. PMs will also be eligible for bonus payments based on quality and process improvements.

PATIENT MANAGER ENROLLMENT LIMITS

Patient managers agree to accept members up to the maximum number that the Patient Manager Agreement designates. The patient manager may not discriminate on the basis of age, race, creed, color, national origin, sex, religion, political affiliation, physical or mental disability, or health status.

Each participating patient manager is allowed a maximum of 1500 enrollees under the Iowa Wellness Plan. For auxiliary staff, such as a Physician Assistant, an additional 300 enrollees may be added to this maximum enrollment. Exceptions to this limit may be granted under special circumstances at the discretion of DHS.

At the time the Agreement for Participation as an Iowa Wellness Plan Patient Manager (470-5177) is signed, a provider can designate a lower maximum number of enrollees that they will accept; there is no minimum number of enrollees required. This limit can be changed with written notification. Once a provider's enrollment limit is reached, the IME computer system will not allow further enrollments with that Patient Manager unless the patient manager's office notifies IME Provider Services to approve additional enrollments.

The Patient Manager's medical service area consists of the county in which their practice is located and any contiguous counties they designate. A patient manager may serve members in his or her primary county and also may elect to serve members from contiguous counties. In order to enroll patients from contiguous counties, the counties must be included in the patient manager's agreement. Enrolling patients from outside the medical service area designated within the Agreement requires the patient manager to contact IME Provider Services by phone, email, or fax (contact information available at the end of this document). Both provider and patient should be aware that, except for emergencies, the patient must access medical services from the patient manager and not from emergency rooms or other providers.

PATIENT MANAGER REIMBURSEMENT

Iowa Wellness Plan providers continue to receive fee-for-service reimbursement from Medicaid for payable services provided to the Iowa Wellness Plan members. In addition, an administrative fee of $4.00 is paid per month for each eligible Iowa Wellness Plan patient enrolled with the Patient Manager. This fee is paid each month

regardless of whether the patient requires services from the Patient Manager. Payment is made the month following the month in which the member was enrolled with the provider.

There is an annual physical exam bonus of $10.00 per member, for each member, that receives a physical exam during performance periods one and two when at least 50 percent of the assigned members have received a physical exam. Only members assigned to the patient manager for at least six months are eligible for consideration of the $10.00 bonus payment.

A voluntary Medical Home Value Index Score (VIS) bonus of *up to* $4.00 per member per month paid on a quarterly basis based on quality measurements identified by the Department is also available. The details of the attribution methodology are available on the Medical Home Bonus document available at: www.dhs.state.ia.us/uploads/MedicalHomeBonus_Final_12262013.pdf.

Participating Iowa Wellness Plan patient managers can earn a partial bonus payment (50% of payment) if their quarterly VIS percentage is greater than midpoint between the Baseline and Target Improvement Goal.

MANAGED SERVICES

The following categories of service must either be provided by, referred or recommended by the Patient Manager or referred specialist to be payable by Medicaid:

- Primary Care Services (Provided through member's primary care provider)
- Specialty Visits
- Home Health Services
- Chiropractic Care
- Outpatient Surgery
- Second Surgical Opinion
- Allergy Testing
- Chemotherapy
- IV Infusion Services Radiation Therapy
- Dialysis
- Non-Emergent Emergency Room Services
- Emergency Transportation-Ambulance and Air Ambulance
- Urgent Care/Emergency Clinics (non-hospital)
- General Inpatient Hospital Care
- Inpatient Physician Services
- Inpatient Surgical Services
- Non-Cosmetic Reconstructive Surgery
- Transplants
- Congenital Abnormalities Correction

- Anesthesia
- Hospice Care
- Hospice Respite
- Skilled Nursing Facility, limited to 120 days annually.

NON-COVERED BENEFITS

- Acupuncture
- Infertility Diagnoses and Treatment
- Bariatric Surgery
- Hearing Aids
- Vision materials-Eye Glasses
- Nursing Facility Services, except for rehabilitation not to exceed 120 days.
- Residential Services
- Non-emergency Transportation Services
- Any other services not covered by the medical assistance program.

Services provided during a medical emergency and billed with an emergent diagnosis code do not require referral. After treatment of the medical emergency, the provider of the service is asked to inform the Patient Manager in a timely manner, during regular business hours, to maintain continuity of care. Additionally, follow-up treatment must be performed either by or through referral from the Patient Manager. The Patient Manager is responsible for issuing/denying referrals for all hospital admissions and services covered under pre-procedure review.

Members have the option of paying for services if the Patient Manager denies a referral. However, services may not be billed to the member unless the member was notified prior to the rendering of the service that he or she may be responsible for the bill and they agreed to be responsible. This allows members to make the decision whether or not to continue to receive service if they will be held financially responsible.

Members enrolled in the Iowa Wellness Plan program (not HMOs) are exempt from pre-procedure and pre-admission review by Medical Services in most cases. The Patient Manager's referral replaces these reviews. Gastroplasty and transplants require referral from both the Patient Manager and Medical Services. If Medical Services denies authorization, the Patient Manager's referral does not override the Medical Services denial. If the Patient Manager denies the referral when Medical Services approves the procedure, the procedure is not authorized.

REFERRAL PROCESS AND DOCUMENTATION

Referrals for payment require no special referral forms under the Iowa Wellness Plan. Referrals should be conducted according to accepted practice in the medical community. The Patient Manager's referral number is that provider's NPI provider

number. This number must appear on CMS 1500 claim form or on the UB-04 claim form to allow an Iowa Wellness Plan member's claim to be paid.

When making a referral, Patient Managers must provide the specialist or other medical provider with the Patient Manager's NPI number to signify that the service is authorized. A referral indicates a Patient Manager's approval for another provider to receive payment for services and does not speak to quality or appropriateness of care delivered. All expectations, limitations, and restrictions that the provider is placing on the use of his or her number should be communicated with the referral (e.g., purposes, length of referral, and involvement of other providers). At the Patient Manager's discretion, referrals may be made for a single visit or an extended period, such as the duration of an illness or a specific number of months.

With the Patient Manager's approval, the referral number may be relayed from one intermediate provider to another. For example, when a Patient Manager refers a patient to a specialist for testing and diagnosis of a particular condition, the specialist may order diagnostic tests as part of the evaluation of the patient. With the Patient Manager's approval, the specialist may in turn relay the referral number (e.g., radiologists, anesthesiologists, laboratories).

A referral by a provider on call or covering for a Patient Manager is considered to be the same as a referral by the Patient Manager. The covering provider should use the Patient Manager's referral number for such referrals. The covering provider does not have to be an Iowa Wellness Plan participating provider. He or she makes referrals and acts on the Patient Manager's behalf in referring services for Iowa Wellness Plan enrollees. Patient Managers should have procedures in place to ensure that referrals are documented.

Retroactive referrals are made at the discretion of the patient manager. Providers may contact the patient manager on behalf of a member to obtain referral for a service if referral was not obtained in advance. If the referral is granted, covered services may be reimbursed by Medicaid. If the referral is refused, no reimbursement will be made. If the patient decides to engage the practitioner for services without a referral from their patient manager, then the services rendered for that specific date will be the member's responsibility. Members may be billed for such services ONLY if the member has specifically been informed in advance of the service that the service is not covered by Medicaid and that the member will be responsible for the bill. It is strongly suggested that providers fully explain this and receive specific permission to bill the patient in writing.

Appropriate use of the patient manager's referral number is verified with the patient manager on a random basis. Unauthorized use of the number will result in action being taken by the Department of Human Services to recover unauthorized reimbursements from the billing provider.

ROUTINE, URGENT, AND EMERGENCY CARE

Medicaid members are educated on an ongoing basis regarding the proper way to seek medical services under the Iowa Wellness Plan. The following guidelines are provided to members in written form, as well as to Medicaid providers via informational releases and provider manuals. The Patient Manager and office staff, assisted by staff at the IME, is encouraged to continually reinforce this information.

Routine Care is defined as care that can wait for a scheduled appointment. Routine care should be provided by the Patient Manager or authorized to an appropriate Medicaid provider by the Patient Manager. The Patient Manager can refer routine care in an emergency room, but should only do so if the ER is the only feasible back-up provider after regular office hours or if there is any question about whether or not the care required can wait until a regularly scheduled appointment. Iowa Wellness Plan members who request and receive routine care without referral from their Patient Manager are responsible for paying the cost of such care only if properly notified by the provider rendering the service. Attending providers may contact the patient manager on behalf of the patient to obtain a referral, but the patient manager is in no way obligated to provide such referral.

Urgent Medical Condition is defined as care for a medical condition manifesting itself by acute symptoms that are of lesser severity (including pain) than that recognized for an emergent condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
- Impairment to bodily functions, or
- Dysfunction of any bodily organ or part

If the member is assigned to a patient manager, the patient manager shall arrange for necessary care within 24 hours by either providing the care or issuing a referral to another appropriate provider for care.

Emergency Care is defined as care needed for an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions

- Serious dysfunction of any bodily organ or part

Treatment in an emergency situation does not require a referral from the Patient manager. The Patient manager referral (NPI) number is not required on claims with an emergency diagnosis.

True medical emergencies are defined by the diagnosis codes available through the IME website at www.ime.state.ia.us/docs/EmergencyDiagnosisCodes.xls. The provider of emergency services should contact the Patient manager in a timely manner during regular business hours to advise the Patient manager of the treatment that was rendered. **Follow-up treatment is to be provided by or through referral from the Patient manager.**

ELIGIBILITY VERIFICATION

Iowa Wellness Plan members receive an identification card from DHS when they first become eligible. Eligibility may be verified by calling the Eligibility Verification System (ELVS) at 1-800-338-7752 or 515-323-9639. This computerized system is available 24-hours a day, seven days a week. ELVS uses either the member's Person ID number or both the date of birth and Social Security Number to access eligibility information. The Web Portal is available to verify eligibility and/or the member's patient manager. The Web Portal is available at: https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do

A New Enrollment letter with a tentative provider assignment, a Confirmation Letter, or Iowa Wellness Plan Patient Listing should never be used as verification of Medicaid eligibility.

DISENROLLMENT OF AN IOWA WELLNESS PLAN MEMBER

Despite the best efforts of those involved, there are times when a satisfactory provider-patient relationship cannot be established or maintained. A mechanism is in place for patient managers to disenroll or 'fire' members in these situations. Disenrollment must be made only for good cause as determined by DHS and may not constitute a practice of discrimination. A Request for Disenrollment, form 470-2169, available at www.ime.state.ia.us/Providers/Forms.html, must be completed and submitted along with the necessary documentation to IME Provider Services. The member will be given an opportunity to respond to the request for disenrollment before final determination.

A member may only be disenrolled or 'fired' from the practice for good cause. Examples of good cause for disenrollment include but are not limited to: failure on the part of the patient to follow treatment plans, repeated failure to keep appointments,

abusive behavior toward providers or office staff, drug-seeking behavior, and seeking unauthorized care from others.

All Disenrollments must be based on behavioral issues and not monetary issues. Disenrollment of a member may not be based on discriminatory practices. The provider's business or practice policies also qualify if applied equally to all patients. Medicaid providers may not discriminate against Medicaid members on the basis of age, race, creed, color, national origin, sex, religion, political affiliation, physical or mental disability or health status. DHS makes the final determination of the criteria that constitute good cause.

DISENROLLMENT PROCESS

The form is completed by the patient manager and submitted to IME Provider Services. IME staff will process the request as quickly as possible, consulting with DHS when necessary.

The member is notified of the patient manager's request to disenroll and given five days to respond. If the member does not respond, processing of the disenrollment continues. If the member does respond, IME staff will work with the patient manager and the member in an attempt to reach a resolution.

The patient manager must continue to treat the member or issue a referral to another provider until the disenrollment becomes effective. Processing the disenrollment request may take from 30 to 45 days. A change in patient managers is effective only when ELVS reflects the change.

MONTHLY PATIENT LISTING

The Patient Listing is available to each participating Iowa Wellness Plan patient manager at the beginning of each month listing the Medicaid members who are enrolled with the manager. It lists members who are currently enrolled with the patient manager (indicated by a C next to their name), members who are new to the patient manager as of that month (N), and members who are either potential enrollees or previous enrollees (P). If a member is reinstated, his or her enrollment with the patient manager is also reinstated. Previous members are those who were enrolled with the patient manager the previous month but are not for the current month.

The $4.00 administrative payment is made for members who show as a C or an N. Payment will also be made for members with a status of a P that have been reinstated during the month. The administrative payment is made at the end of the month following the month of the Patient Listing. A member who was disenrolled will show on the Patient Listing as a P in the month following the disenrollment.

A cover letter accompanies the monthly Patient Listing. The final page of the report is a summary sheet and shows the total number of N, C, and P Iowa Wellness Plan enrollees for the month. It also indicates the total number of patients enrolled with the patient manager.

The Patient Listing is also accessible through the Iowa Medicaid Portal Access (IMPA) tool through the link: https://secureapp.dhs.state.ia.us/impa. User registration instructions are available through this link: www.ime.state.ia.us/docs/IMPAUserRegistration.pdf.

INFORMATIONAL LINES

The IME has established informational telephone lines for both members and providers to facilitate understanding of the Iowa Wellness Plan and to assist in resolution of problems or grievances related to services provided under the Iowa Wellness Plan, requests for enrollment choices, and changes in patient managers. The phone lines are staffed Monday through Friday 8:00 A.M. to 5:00 P.M. for members, and Monday through Friday 7:30 A.M. to 4:30 P.M. for providers, except for holidays. The Eligibility Verification System (ELVS) is a 24-hour number that can be used to verify eligibility and to obtain the Iowa Wellness Plan provider's name and phone number if the patient is in the Iowa Wellness Plan.

- Eligibility Verification System (ELVS): 1-800-338-7752 or 515-323-9639
- Web Portal: https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do
- IME Member Services 1-800-338-8366 or 515-256-4606 (Des Moines area)
- IME Provider Services 1-800-338-7909 or 515-256-4609 (Des Moines area)
- IME Provider Services Fax 515-725-1155
- IME Provider Services Email: IMEProviderServices@dhs.state.ia.us.